Arizona State University

Name: _____ ASU ID#:_____

ASU Health Services International Travel Questionnaire

Today's Date: _____

Your Phone Number: ( ) _____ May we leave voicemail if needed? Y or N

Departure Date: _____/_____/_____ Return Date: _____/_____/_____

Your itinerary (please list all countries, cities/towns and ALL excursions planned): _____

_____

_____

Please complete & submit this ASU Travel Questionnaire at least 4 weeks before your departure date so that you have adequate time to medically prepare for your trip. Please note that, in general, it takes at least 2 weeks for most vaccines to become effective.

Travel appointments are available at all ASU Health Services locations. After submission of your International Travel Questionnaire, you will be contacted by an ASU Health Services staff member to schedule your travel clearance appointments. It usually takes 3-5 days after receipt of the form to schedule travel appointments.

Insurance/Billing: ASU Health Services will submit a bill to your medical insurance company on your behalf. Students are financially responsible for all travel appointment charges not covered by their insurance plans. All costs will be sent to Student Accounts. It is recommended that you contact your medical insurance plan prior to your travel appointment to determine out-of-pocket costs not covered under your plan.

Using Your Own Primary Care Provider (outside of ASU Health Services): If you wish to see your own primary care provider or need to see a provider that is contracted with your insurance plan, please contact the ASU Global Education Office at (480) 965-5965 or goglobal@asu.edu to request this option

Travel Appointments for ASU Online Students: If you are enrolled through ASU Online, you will need to see a community medical provider in order to complete your travel appointment. Please contact the ASU Global Education Office at (480) 965-5965 for appropriate documentation and/or a list of available providers.

Please make sure to note on the questionnaire any current medical issues and/or if there are any ADDITIONAL non-ASU forms that need to be completed (CIEE, ISA, Semester at Sea, Fulbright, Peace Corps, Missionary or VISA applications, etc) so that we can schedule you with the appropriate medical provider. Otherwise you may be asked to schedule another appointment to address these concerns/forms.

***FOR ASU GLOBAL EDUCATION STUDENTS: by signing below, you authorize ASU Health Services to share with the ASU Global Education Office (and those individuals responsible for coordinating your Global Education program) any pertinent but required medical information for your medical clearance (including minimally necessary details on any medications and medical conditions of concern). ASU Health Services does not make decisions about allowing students to participate in ASU Global Education programs- we assess risk and make recommendations to both the student and ASU Global Education Office on how to mitigate these risks.

****If you wish to opt out of this and discuss this further at your visit, please initial here*: _____

Signature: _____ Date: _____

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Once completed, please upload this entire document on your Health Services patient portal in the Downloadable Forms section. Remember to hit "SAVE" at the bottom of the Downloadable Forms page in order to submit this document. Someone from Health Services will reach out to you by phone within 2-3 days after receipt of this form.

	YES	NO
Aside from the ASU Global Education Office's required medical clearance, do you have a **separate or additional non-ASU** Medical Clearance form that needs to be completed for studying/working/traveling? **Examples: CIEE, ISA, Semester at Sea, Fulbright, Peace Corps, Missionary, or VISA etc- these forms require specific provider signatures, so if applicable please mark "Yes" to avoid scheduling errors**		
Do you have a medical condition that warrants medications or regular physician care (for example: high blood pressure, asthma, diabetes, depression, anxiety, ADHD etc.)?		
Are you 55 years or older?		
Aside from diarrheal/anti-malaria medications and travel vaccinations, will be you requesting ***additional*** prescriptions (including medication refills) at this visit? *Please note that chronic medications generally need to be filled by your primary care provider and not by the travel visit provider.*		
Will the length of your travel be 3 months or greater in Asia, Africa or South America?		

Have you had a fever in the past 48 hours and/or are you feeling sick today?		
Do you have a chronic cough?		
Do you have a new rash or ongoing rash that has not been evaluated?		
Are you pregnant or might you become pregnant on this trip?		
Do you have HIV/AIDS, an AIDS-like condition, any other immune disorder, leukaemia, or cancer?		
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?		
Do you have a low platelet count, a bleeding problem, or blood clotting disorder?		
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or a brain infection?		
Do you have G6PD deficiency?		
Do you have any chronic kidney problems?		
Do you have a chronic gastrointestinal condition such as ulcers, chronic diarrhea or colitis?		
Have you ever had hepatitis or yellow jaundice?		
Do you have any active mental health issues that require counseling or medications?		
Do you have recurrent nightmares or recurrent anxiety?		
Do you have recurrent or active asthma or a history of anaphylaxis (life-threatening allergic reaction)?		
Do you have any heart disease, with or without symptoms?		
Do you have any chronic eye conditions **aside** from corrective lenses (glasses, contacts)?		
Have you received an organ transplant?		
Are you or will you be taking steroids/prednisone, immune suppressants or anti-cancer drugs?		

Have you ever fainted from having your blood drawn or from an injection?		
Have you ever had a fever or adverse reaction to a vaccination?		
Do you live (or work closely) with anyone who has AIDS, any other immune disorder, on immune suppressive therapy or on chemotherapy for cancer?		
Does any person who lives with you or any person you take care of take cortisone, prednisone, other steroids, or receive radiation treatments?		

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Immunization and Allergy History

******PLEASE BRING A COPY OF YOUR PREVIOUS VACCINATION RECORD TO YOUR VISIT FOR MEDICAL PROVIDER REVIEW AND CONFIRMATION***

Vaccination History (please complete any known dates below)					
MMR (mumps, measles, rubella)	1. 2.	Tetanus (DPT, DTaP, Td, Tdap)	1. 4. 2. 5. 3. 6.	Varicella (Chicken Pox)	1. 2. or Previous Illness ( ) year
Hepatitis A Hepatitis B	1. 2. 1. 2. 3.	Polio	1. 2. 3. 4. 5.	Influenza (flu)	Last date received
Meningitis (*ACWY* or Men*B*, circle type if known)	1. 2. 3.	Typhoid (oral or injectable, circle type if known)	1. 2.	Pneumonia (Pneumovax PPSV23 or Prevnar 13)	1. 2.
Human Papilloma Virus (HPV)	1. 2. 3.	Yellow Fever Cholera	1. 2. 1.	Japanese Encephalitis Rabies	1. 2. 1. 2. 3.
Other vaccinations received not listed above:					
Please list any previous vaccine adverse reactions:					

Are you allergic to any of the following below? (circle those that apply and indicate reaction details below)

Eggs	Yeast	Gelatin	Bee Stings	Latex	Aluminium
Penicillin	Sulfa/Sulfur	Thimerosal	Phenol	Neomycin	Streptomycin
Formalin	Polymyxin B	Amphotericin B	2-phenoxyethanol		
Chlortetracycline	Protamine Sulfate				

Adverse Reaction Detail (if any above circled):